

New patients to our practice,

We would like to welcome you to Western Carolina Ear, Nose, and Throat Specialists. To best serve your needs, we have provided you with many of the forms needed for your first visit on the pages that follow. Without much of this information, your visit may be delayed or you may require additional visits to complete your evaluation. These forms are only required at your first visit. Please review the following carefully, complete the attached forms accurately, and bring them to your office visit with you.

**You will need to bring with your at the time of your initial visit and subsequent visits:**

1. **Updated/current insurance card along with photo ID of policy holder** – please confirm that we are providers for your plan as this is your responsibility
2. **Photo identification**
3. **Current medication list**
4. **Payment for copay** as required by your insurance company
5. If no insurance or if our staff cannot verify your insurance, we require full payment at the time of the service.
6. **Referral records** from your referring MD if not already provided to the practice. If your insurance requires a referral from a primary care physician, your appointment will be cancelled id we have not received authorization by the time of your appointment.

**If the patient is a minor**, a parent or legal guardian must accompany them and be present for every visit, or parent or legal guardian must sign a child care consent with a copy of their photo ID. Please bring:

1. Photo identification
2. Written documentation that you have legal custody or guardianship of the child, notarized if required

**If your insurance requires a referral** from a primary care physician, your appointment will be cancelled if we have not received authorization by the time of your appointment. We do require payment at the time of service for all copays required by your insurance company, and if not insured we require payment of $100 at the time of the initial visit. Any additional charges are based upon testing and services provided. We do accept payments of cash, check or Credit Card. After your visit, further diagnostic procedures or tests may be required to care for you and depending on your insurance, additional co-payment, deductible, or referrals/authorizations may be required.

Thank you for choosing our practice for your ENT specialty healthcare needs. We look forward to meeting with you soon.

Sincerely,

***Dr. Wenzel and Staff***



**PATIENT CLINICAL INFORMATION FORM**

**Clinic Visit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Primary care MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| ALLERGIES □ check here if NO ALLERGIES |
| --- |

**Please circle any allergies:**

**Medications:** Penicillin Cephalosporins Sulfa Mycins Iodine/betadine Quinolones

**Other:** Latex/rubber Cornstarch Adhesive Tape Local anesthesia Shellfish Anesthesia

What type of reaction did you have? Itching Rash Throat Swelling

List any other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| SOCIAL HISTORY |
| --- |

**Average alcohol use (circle):** never daily weekly - how many drinks in that time? 1-3 3-6 more

**Do you use tobacco?** (circle): never former smoker chewing tobacco cigars

If so, average packs smoked per day: \_\_\_\_\_\_\_\_

**Living situation (circle):** private home nursing facility other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives with you? Spouse children significant other Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| FAMILY HISTORY |
| --- |

Circle if you have family history of the following:

Heart disease Anesthesia sensitivity Migraine Headaches

Bleeding or bruising tendency Anemia Arthritis or autoimmune diseases

Other hereditary diseases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| CHRONIC MEDICAL PROBLEMS |
| --- |

Please check off any medical problems you have been diagnosed with:

□ Anemia □ Coronary artery disease □ Heart Murmur □ Thyroid problems

□ Anxiety □ Stroke/CVA □ Heart Disease □ Otosclerosis

□ Arthritis □ Depression □ High Cholesterol □ Seizure Disorder

□ Asthma □ Diabetes □ Hypertension □ Sleep apnea

□ Bleeding disorder □ Emphysema □ Hepatitis □ Stomach ulcers

□ Chronic infection □ Gerd/reflux □ Irregular heartbeat □ Tinnitus

□ Congestive heart failure □ Glaucoma □ Kidney disorder □ Vertigo

□ COPD □ Headaches □ Migraine headaches □ Anesthesia reactions

**Other medical problems** not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancer history** with date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| SURGERIES |
| --- |

Please list

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Surgery | Date | surgery |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Reason for clinic visit**

**What is the main reason/symptom you are here?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Describe your main problem:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where is the problem located: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this problem first start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does it last? (ie, days or hours, constant) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does the problem occur? (ie, daily, monthly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it better/worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any diagnostic tests done so far? (ie, labs, CT, MRI)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any treatments performed so far? (ie. surgery)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any related problems or symptoms (ie. fever, cough, etc)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| REVIEW OF SYSTEMS = CURRENT SYMPTOMS YOU ARE HAVING |
| **Please check only the symptoms which you are *CURRENTLY* experiencing now (no check means negative).**   |  |  | | --- | --- | | **General:** | **🗆** **recent weight change? \_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_**  **🗆 fevers 🗆 fatigue**  **🗆 headaches 🗆 other: \_\_\_** | | **Ears:** | **🗆 hearing loss 🗆 ringing 🗆 drainage**  **🗆 pain 🗆 fullness** | | **Mouth/Throat:** | **🗆 sores 🗆 throat pain**  **🗆 voice changes 🗆 difficulty swallowing** | | **Eyes:** | **🗆 eye injury 🗆 wear glasses/contacts**  **🗆 blurred vision 🗆 glaucoma** | | **Nose:** | **🗆 nasal congestion 🗆 drainage**  **🗆 bleeding 🗆 loss of smell, altered smell** | | **Neck:** | **🗆 stiffness or pain 🗆 lumps, swelling**  **🗆 swollen glands 🗆 thyroid problems** | | **Digestive/Urinary:** | **🗆 burning with urination 🗆 constipation**  **🗆 frequent diarrhea 🗆 nausea and vomiting** | | **Muscular:** | **🗆 daily joint pain 🗆 daily joint swelling**  **🗆 daily muscle weakness 🗆 daily muscle pain or cramps** | | **Psychiatric:** | **🗆 severe memory loss 🗆 daily nervousness**  **🗆 unable to sleep, insomnia 🗆 depression** | | **Skin:** | **🗆 lumps, enlarging 🗆 rashes**  **🗆 daily itching 🗆 sores that do not heal** | | **Heart/Lungs:** | **🗆 chest pain 🗆 shortness of breath**  **🗆 wheezing 🗆 daily cough** | |

*(Office use only) I have reviewed the above information with the patient:*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS**

**Medication allergies □ cHECK HERE FOR NO ALLERGIES**

|  |  |  |  |
| --- | --- | --- | --- |
| SUBSTANCE | REACTION | SUBSTANCE | REACTION |
| 1. | 1. | 4. | 4. |
| 2. | 2. | 5. | 5. |
| 3. | 3. | 6. | 6. |

Your complete medication history is important to us. Please fill out this form and bring it with you anytime you go to the doctor’s office or to the hospital. If you are unable to fill out the form, please bring in a bag of all of the medications (in their original containers) that you are currently taking.

**CURRENT Medication list** □ SEE ATTACHED MEDICATION SHEET IF CHECKED

**Please list ALL prescription and non-prescription medications, herbal products, eye drops, nutritional supplements, inhalers, etc. that you use.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME OF MEDICINE | DOSE  (MG, UNITS, ETC.) | ROUTE  BY MOUTH | DIRECTIONS  HOW OFTEN DO YOU TAKE | PURPOSE  WHY DO YOU TAKE |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**patient**: As the patient or patient’s legal guardian, I hereby certify that the information given above and on the preceding pages is true and accurate to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Patient’s or Legal Guardian’s signature** Date